STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 01 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/02/11 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, West Bend Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000	The creation and submission of this Plan of Correction does not consttitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	This facility consists of two connected buildings: the original building built in 1967, a one story building with a partial basement and the 1976 building, a two story building, both buildings are determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors and resident sleeping rooms. The facility has a capacity of 177 and had a census of 85 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/14/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 79 resident room doors would latch into the door frame or were provided with a device that exerts at least 5 pounds of pressure to keep the door tightly closed. This deficient practice could effect occupants in and near resident room # 9, including staff, visitors and residents. Findings include: Based on observation on 11/02/11 at 2:00 p.m. with the maintenance supervisor, the corridor door to	K0018	**What corrective action(s) will be taken for those residents, staff or visitors found to have been affected by the alleged deficient practice?** K 018 Resident room door #9 has been repaired with a device to ensure the door latches and can sustain at least 5 pounds of pressure to keep the door tightly closed. **How will you identify other residents have the potential to be affected by the same deficient practice and what corrective action will be taken?** Maintenance staff have conducted a full house audit of resident room doors to ensure they properly latch and sustain at least 5 pounds of pressure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	11/18/2011

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	resident room # 9 was not equipped with a latch that latched into the door frame or a device to provide at least five pounds of pressure to keep the door closed. The maintenance supervisor stated at the time of observation, he was not aware of the problem. 3.1-19(b)		**program will be put into place?** Maintenance Supervisor or designee will monitor during routine preventative maintenance. Doors will be audited as part of for CQI program.	

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K0029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 doors serving hazardous areas such as a boiler and furnace room closed and latched to prevent the passage of smoke. This deficient practice could affect visitors and staff in and near the boiler and furnace room located in the partial basement. Findings include: Based on observations with the maintenance supervisor on 11/02/11 at 3:40 p.m., the door to the boiler and furnace room door was blocked open by a cement block. When the block was	K0029	**What corrective action(s) will be taken for those residents, staff or visitors found to have been affected by the alleged deficient practice?** K 029 It is the practice of West Bend Nursing & Rehab to doors to hazardous areas are closed and latched. The door to the boiler room closes and latches as required. Signage has been posted to ensure the door is closed and latched at all times. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Supervisor or designee will monitor during routine preventative maintenance. Doors will be audited as part of for CQI program.	11/02/2011

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	removed, the door was self closing and latched into the door frame. The maintenance supervisor acknowledged the problem area at the time of observation. 3.1-19(b)			

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K0045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 2 exits from the basement. This deficient practice could affect staff and visitors in the facility's partial basement. Findings include: Based on observation during a tour of the facility with the maintenance supervisor on 11/02/11 at 3:55 p.m., the two exit discharges for the basement were equipped with one light fixture with a single bulb. The maintenance supervisor stated at the time of the observation, he did not realize the exits had single bulb lighting. 3.1-19(b)	K0045	**What corrective action(s) will be taken for those residents, staff or visitors found to have been affected by the alleged deficient practice?** K 045 Egress lighting has been installed to 2 of 2 exits from the basement as identified during survey. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** All egress lighting in tested routinely during monthly preventation maintenance and CQI audits.	11/10/2011

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K0047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to provide proper signage for 2 of 2 exit access doors in the facility's partial basement in accordance with LSC 7.10.2. LSC 7.10.2 requires a sign with directional indicators be placed in all locations where to travel to reach the nearest exit is not apparent. This deficient practice could effect staff and visitors in the basement. Findings include: Based on observation with the maintenance supervisor on 11/02/11 at 3:50 p.m., the two exits from the partial basement had no signage provided which indicated the direction to the nearest "EXIT." The maintenance supervisor stated, he was aware of the problem. 3.1-19(b)	K0047	**What corrective action(s) will be taken for those residents, staff or visitors found to have been affected by the alleged deficient practice?** K 047 Proper signage to alert staff and visitors to direction of nearest "Exit" has been installed to partial basement.	11/10/2011

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K0048 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written fire plan which included the use of kitchen fire extinguishers for the protection of 177 of 177 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect any occupants in and near the kitchen in the event of an emergency when the written fire plan should be immediately	K0048	**What corrective action(s) will be taken for those residents, staff or visitors found to have been affected by the alleged deficient practice?** K 048 Facility fire and disaster plan will be updated to include the use of "K" class fire extinguisher, which is located in the kitchen. **How will you identify other residents have the potential to be affected by the same deficient practive and what corrective action will be taken?** Maintenance Director or designee will educate staff on use of "K" class extinguisher, including the location of instructions for use. **What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Staff will be educated on facility fire plan upon hire and at least 2 times annually. Fire and disaster plan training will be included on Annual In-Service calendar. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CQI committee will review fire and disaster plan to ensure instructions for use of "K" class extinguisher is	11/22/2011

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	available. Findings include: Based on interview and record review with the maintenance supervisor and facility administrator on 11/02/11 from 2:40 p.m. to 3:05 p.m., the written fire plan was found within the Emergency Procedure manual. The maintenance supervisor was not sure when the policy and procedure was last reviewed. This Plan was the corporate policy which did not include information specific to this facility. The manual did not address the use of the K class fire extinguisher in relationship with the use of the kitchen hood suppression system. The maintenance supervisor stated he was unaware of the requirement for the policy and procedure. 3.1-19(b)		present 12/21/11 and at least annually by CQI Committee.	

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K0069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. LSC 19.3.2.6 requires cooking facilities to be in compliance with 9.2.3 which requires commercial cooking equipment to be in compliance with NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, at 8-3.1 requires the cleaning of the hood every six months for systems serving moderate food volumes, by properly trained and qualified staff persons. This deficient practice could effect residents, staff and visitors in and near the kitchen area. Findings include: Based on review of the	K0069	**What corrective action(s) will be taken for those residents, staff or visitors found to have been affected by the alleged deficient practice?** K 069 Hood extinguishing systems in kitchen must be inspected and serviced every six months. The sticker present on the kitchen hood reflects service on June 1, 2011. There was no deficient practice.	11/02/2011

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	documentation available for the kitchen hood cleaning at 2:15 p.m. on 11/02/11 with the maintenance supervisor, the kitchen hood had not been cleaned and serviced since 07/07/10, a period greater than six months. The maintenance supervisor stated he was certain the hood had been cleaned but had no documentation. 3.1-19(b)			

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure 2 of 2 emergency generators were equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the	K0144	**What corrective action(s) will be taken for those residents, staff or visitors found to have been affected by the alleged deficient practice?** K 144 Life Safety requires generators equipped with remote manual stops. Remote manual stops were installed for 2 of 2 generators 11/18/11. The facility routinely tests generators and emergency battery lighting. The emergency battery lighting was tested on This documentation was reviewed by Life Safety surveyor at time of visit. Emergency lighting was tested again during preventative maintenance with contractor on 11/8/11.	11/18/2011

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	engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors in the event of an emergency. Findings include: Based on review of the Generator Maintenance records on 11/02/11 at 1:35 p.m. with the maintenance supervisor and facility administrator, there was no documentation available which indicated the horsepower rating of the generator engines provided. Based on interview with the maintenance supervisor during record review, he stated no remote shut off devices existed for the generators. The maintenance supervisor indicated the smaller of the two generators was installed prior to 2003. 3.1-19(b) 2. Based on record review and interview, the facility failed to			

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	ensure emergency task lighting in and around 2 of 2 generator sets was in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.3 requires an annual functional test to be conducted on emergency battery lighting systems for not less than 90 minutes. NFPA 110, Section 5-3.1 requires that EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the maintenance supervisor and facility administrator on 11/02/11 at 1:35 p.m., the maintenance supervisor acknowledged he had no record of the battery powered lighting at the generators being tested for 90 minutes annually. The maintenance supervisor stated he thought the annual 90 minute tests had been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 01 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	completed but had no documentation. 3.1-19(b)			